Sense of the Senate Concerning U.N. Peacekeepers.—This section expresses the Sense of the Senate that the UN Secretary General should strengthen the United Nations' capability to prevent and respond to violence against civilian women and girls by United Nations Peacekeepers.

Sec. 104. Inclusion of Information on Violence Against Women and Girls in Human Rights Reports.—This section amends Section 116(d) of the Foreign Assistance Act of 1961 (22 U.S.C. 2151n) to include a description of the nature and extent of violence against women in the Department of State's annual Human Rights Report.

TITLE II: OTHER PROVISIONS

Sec. 201. Amendments to Foreign Service Act of 1980.—This section amends Section 405 of the Foreign Service Act of 1980 (22 U.S.C. 3965) to provide that service in the promotion of human rights, including the rights of women and girls, will serve as a basis for performance pay.

Sec. 212. Training for Foreign Service Officers.—This section amends Chapter 2 of title I of the Foreign Service Act of 1980 to provide for training for foreign service officers on international violence against women.

Sec. 202. Support For Multilateral Efforts to End Violence Against Women and Girls.—This section authorizes the appropriation of $5,000,000 for each of fiscal years 2008–2012 to the United Nations Development Fund for Women (UNIFEM) Trust Fund in Support of Actions to Eliminate Violence Against Women.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 361—TO PERMIT THE COLLECTION OF DONATIONS IN SENATE BUILDINGS TO BE SENT TO UNITED STATES MILITARY PERSONNEL ON ACTIVE DUTY OVERSEAS PARTICIPATING IN OR IN SUPPORT OF OPERATION IRAQI FREEDOM, OPERATION ENDURING FREEDOM, AND THE WAR ON TERRORISM

Mr. MCCONNELL (for himself, Mr. REID, and Mr. BENNETT) submitted the following resolution; which was considered and agreed to:

S. RES. 361

Resolved,

SECTION 1. COLLECTION OF DONATIONS TO UNITED STATES MILITARY PERSONNEL.

(a) IN GENERAL.—Notwithstanding any other provision of the rules or regulations of the Senate—

(1) a Senator, officer, or employee of the Senate may collect from another Senator, officer, or employee of the Senate within Senate buildings nonmonetary donations to be sent to United States military personnel on active duty overseas participating in or in support of Operation Iraqi Freedom, Operation Enduring Freedom, and the war on terrorism; and

(2) a Senator, officer, or employee of the Senate may work with a nonprofit organization with respect to the delivery of donations that are collected as described in paragraph (1).

(b) EFFECTIVE PERIOD.—This resolution shall be in effect until December 31, 2007.

SENATE RESOLUTION 362—RECOGNIZING 2007 AS THE YEAR OF THE 100TH ANNIVERSARY OF THE AMERICAN SOCIETY OF AGRONOMY

Mr. HARKIN (for himself and Mr. CHAMBLISS) submitted the following resolution; which was considered and agreed to:

S. RES. 362

Whereas the American Society of Agronomy was founded on December 31, 1907, with Mark A. Carleton as the first President of the Society;

Whereas the American Society of Agronomy is one of the premier scientific societies in the world, as demonstrated by first-class journals, international and regional meetings, and development of a broad range of educational opportunities;

Whereas the science and scholarship of the American Society of Agronomy are mission-directed, and seek to foster exploration and application of agronomic science, with the goal of increasing and disseminating knowledge concerning the nature, use, improvement, and interrelationships of plants, soil, water, and the environment;

Whereas the American Society of Agronomy strives to obtain that goal by promoting effective research, disseminating scientific information, facilitating technology transfer, fostering high standards of education, striving to maintain high standards of ethics, promoting advancements in the agronomy profession, and cooperating with other organizations with similar objectives;

Whereas the American Society of Agronomy significantly contributes to the scientific and technical knowledge necessary to protect and sustain natural resources in the United States;

Whereas the American Society of Agronomy has a critical international role in developing sustainable agricultural management standards for the protection of land resources;

Whereas the mission of the American Society of Agronomy continues to expand, from the development of sustainable production of food, fiber, and forage, to the production of renewable energy and biobased industrial products;

Whereas the American Society of Agronomy certifies a body of professional Certified Crop Advisors and Certified Professional Agronomists who work closely with agricultural producers to develop nutrient management plans that are designed to minimize environmental risk in production agriculture;

Whereas, in industry, extension, and basic research, the American Society of Agronomy has fostered a dedicated professional and scientific community that, in 2007, includes more than 8,015 members and 13,015 certified crop advisor professionals; and

Whereas the American Society of Agronomy was the parent society that led to the formation of both the Crop Science Society of America and the Soil Science Society of America and later fostered the common overall management of these 3 related societies: Now, therefore, be it

Resolved, That the Senate—

(1) recognizes 2007 as the 100th anniversary year of the American Society of Agronomy;

(2) commends the American Society of Agronomy for 100 years of dedicated service to advance the science and practice of agronomy; and

(3) acknowledges the promise of the American Society of Agronomy to continue to enrich the lives of all citizens, by improving stewardship of the environment, combating world hunger, and enhancing the quality of life for the next 100 years and beyond.

AMENDMENTS SUBMITTED AND PROPOSED

SA 3491. Mr. DEMINT submitted an amendment intended to be proposed by him to the bill H.R. 3963, to amend title XXI of the Social Security Act to extend and improve the Children's Health Insurance Program, and for other purposes; which was ordered to lie on the table.

SA 3492. Mr. DEMINT submitted an amendment intended to be proposed by him to the bill H.R. 3963, supra; which was ordered to lie on the table.

SA 3493. Mr. DEMINT submitted an amendment intended to be proposed by him to the bill H.R. 3963, supra; which was ordered to lie on the table.

SA 3494. Mr. DEMINT submitted an amendment intended to be proposed by him to the bill H.R. 3963, supra; which was ordered to lie on the table.

SA 3495. Mr. DEMINT submitted an amendment intended to be proposed by him to the bill H.R. 3963, supra; which was ordered to lie on the table.

SA 3496. Mr. COBURN submitted an amendment intended to be proposed by him to the bill H.R. 3963, supra; which was ordered to lie on the table.

TEXT OF AMENDMENTS

SA 3491. Mr. DEMINT submitted an amendment intended to be proposed by him to the bill H.R. 3963, to amend title XXI of the Social Security Act to extend and improve the Children's Health Insurance Program, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

TITLE ____—HEALTH CARE CHOICE

SEC. __01. SHORT TITLE.

This title may be cited as ''Health Care Choice Act of 2007''.

SEC. __02. SPECIFICATION OF CONSTITUTIONAL AUTHORITY FOR ENACTMENT OF LAW.

This title is enacted pursuant to the power granted Congress under article I, section 8, clause 3, of the United States Constitution.

SEC. __03. FINDINGS.

Congress finds the following:

(1) The application of numerous and significant variations in State law impacts the ability of insurers to offer, and individuals to obtain, affordable individual health insurance coverage, thereby impeding commerce in individual health insurance coverage.

(2) Individual health insurance coverage is increasingly offered through the Internet, other electronic means, and by mail, all of which are inherently part of interstate commerce.

(3) In response to these issues, it is appropriate to encourage increased efficiency in the offering of individual health insurance coverage through a collaborative approach by the States in regulating this coverage.

(4) The establishment of risk-retention groups has provided a successful model for the sale of insurance across State lines, as the acts establishing those groups allow insurance to be sold in multiple States but regulated by a single State.

SEC. __04. COOPERATIVE GOVERNING OF INDIVIDUAL HEALTH INSURANCE COVERAGE.

(a) IN GENERAL.—Title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.) is amended by adding at the end the following new part:

"PART D—COOPERATIVE GOVERNING OF INDIVIDUAL HEALTH INSURANCE COVERAGE

"SEC. 2795. DEFINITIONS.

''In this part:

''(1) PRIMARY STATE.—The term 'primary State' means, with respect to individual health insurance coverage offered by a health insurance issuer, the State designated by the issuer as the State whose covered laws shall govern the health insurance issuer in the sale of such coverage under this part. An issuer, with respect to a particular policy, may only designate one such State as its primary State with respect to all such coverage it offers. Such an issuer may not change the designated primary State with respect to individual health insurance coverage once the policy is issued, except that such a change may be made upon renewal of the policy. With respect to such designated State, the issuer is deemed to be doing business in that State.

''(2) SECONDARY STATE.—The term 'secondary State' means, with respect to individual health insurance coverage offered by a health insurance issuer, any State that is not the primary State. In the case of a health insurance issuer that is selling a policy in, or to a resident of, a secondary State, the issuer is deemed to be doing business in that secondary State.

''(3) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning given such term in section 2791(b)(2), except that such an issuer must be licensed in the primary State and be qualified to sell individual health insurance coverage in that State.

''(4) INDIVIDUAL HEALTH INSURANCE COVERAGE.—The term 'individual health insurance coverage' means health insurance coverage offered in the individual market, as defined in section 2791(e)(1).

''(5) APPLICABLE STATE AUTHORITY.—The term 'applicable State authority' means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the requirements of this title for the State with respect to the issuer.

''(6) HAZARDOUS FINANCIAL CONDITION.—The term 'hazardous financial condition' means that, based on its present or reasonably anticipated financial condition, a health insurance issuer is unlikely to be able—

''(A) to meet obligations to policyholders with respect to known claims and reasonably anticipated claims; or

''(B) to pay other obligations in the normal course of business.

''(7) COVERED LAWS.—The term 'covered laws' means the laws, rules, regulations, agreements, and orders governing the insurance business pertaining to—

''(A) individual health insurance coverage issued by a health insurance issuer;

''(B) the offer, sale, and issuance of individual health insurance coverage to an individual; and

''(C) the provision to an individual in relation to individual health insurance coverage of—

''(i) health care and insurance related services;

''(ii) management, operations, and investment activities of a health insurance issuer; and

''(iii) loss control and claims administration for a health insurance issuer with respect to liability for which the issuer provides insurance.

''(8) STATE.—The term 'State' means only the 50 States and the District of Columbia.

''(9) UNFAIR CLAIMS SETTLEMENT PRACTICES.—The term 'unfair claims settlement practices' means only the following practices:

''(A) Knowingly misrepresenting to claimants and insured individuals relevant facts or policy provisions relating to coverage at issue.

''(B) Failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising under policies.

''(C) Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under policies.

''(D) Failing to effectuate prompt, fair, and equitable settlement of claims submitted in which liability has become reasonably clear.

''(E) Refusing to pay claims without conducting a reasonable investigation.

''(F) Failing to affirm or deny coverage of claims within a reasonable period of time after having completed an investigation related to those claims.

''(10) FRAUD AND ABUSE.—The term 'fraud and abuse' means an act or omission committed by a person who, knowingly and with intent to defraud, commits, or conceals any material information concerning, one or more of the following:

''(A) Presenting, causing to be presented or preparing with knowledge or belief that it will be presented to or by an insurer, a reinsurer, broker or its agent, false information as part of, in support of or concerning a fact material to one or more of the following:

''(i) An application for the issuance or renewal of an insurance policy or reinsurance contract.

''(ii) The rating of an insurance policy or reinsurance contract.

''(iii) A claim for payment or benefit pursuant to an insurance policy or reinsurance contract.

''(iv) Premiums paid on an insurance policy or reinsurance contract.

''(v) Payments made in accordance with the terms of an insurance policy or reinsurance contract.

''(vi) A document filed with the commissioner or the chief insurance regulatory official of another jurisdiction.

''(vii) The financial condition of an insurer or reinsurer.

''(viii) The formation, acquisition, merger, reconsolidation, dissolution or withdrawal from one or more lines of insurance or reinsurance in all or part of a State by an insurer or reinsurer.

''(ix) The issuance of written evidence of insurance.

''(x) The reinstatement of an insurance policy.

''(B) Solicitation or acceptance of new or renewal insurance risks on behalf of an insurer reinsurer or other person engaged in the business of insurance by a person who knows or should know that the insurer or other person responsible for the risk is insolvent at the time of the transaction.

''(C) Transaction of the business of insurance in violation of laws requiring a license, certificate of authority or other legal authority for the transaction of the business of insurance.

''(D) Attempt to commit, aiding or abetting in the commission of, or conspiracy to commit the acts or omissions specified in this paragraph.

"SEC. 2796. APPLICATION OF LAW.

''(a) IN GENERAL.—The covered laws of the primary State shall apply to individual health insurance coverage offered by a health insurance issuer in the primary State and in any secondary State, but only if the coverage and issuer comply with the conditions of this section with respect to the offering of coverage in any secondary State.

''(b) EXEMPTIONS FROM COVERED LAWS IN A SECONDARY STATE.—Except as provided in this section, a health insurance issuer with respect to its offer, sale, renewal, and issuance of individual health insurance coverage in any secondary State is exempt from any covered laws of the secondary State (and any rules, regulations, agreements, or orders sought or issued by such State under or related to such covered laws) to the extent that such laws would—

''(1) make unlawful, or regulate, directly or indirectly, the operation of the health insurance issuer operating in the secondary State, except that any secondary State may require such an issuer—

''(A) to pay, on a nondiscriminatory basis, applicable premium and other taxes (including high risk pool assessments) which are levied on insurers and surplus lines insurers, brokers, or policyholders under the laws of the State;

''(B) to register with and designate the State insurance commissioner as its agent solely for the purpose of receiving service of legal documents or process;

''(C) to submit to an examination of its financial condition by the State insurance commissioner in any State in which the issuer is doing business to determine the issuer's financial condition, if—

''(i) the State insurance commissioner of the primary State has not done an examination within the period recommended by the National Association of Insurance Commissioners; and

''(ii) any such examination is conducted in accordance with the examiners' handbook of the National Association of Insurance Commissioners and is coordinated to avoid unjustified duplication and unjustified repetition;

''(D) to comply with a lawful order issued—

''(i) in a delinquency proceeding commenced by the State insurance commissioner if there has been a finding of financial impairment under subparagraph (C); or

''(ii) in a voluntary dissolution proceeding;

''(E) to comply with an injunction issued by a court of competent jurisdiction, upon a petition by the State insurance commissioner alleging that the issuer is in hazardous financial condition;

''(F) to participate, on a nondiscriminatory basis, in any insurance insolvency guaranty association or similar association to which a health insurance issuer in the State is required to belong;

''(G) to comply with any State law regarding fraud and abuse (as defined in section 2795(10)), except that if the State seeks an injunction regarding the conduct described in this subparagraph, such injunction must be obtained from a court of competent jurisdiction; or

''(H) to comply with any State law regarding unfair claims settlement practices (as defined in section 2795(9));

''(2) require any individual health insurance coverage issued by the issuer to be countersigned by an insurance agent or broker residing in that Secondary State; or

''(3) otherwise discriminate against the issuer issuing insurance in both the primary State and in any secondary State.

''(c) CLEAR AND CONSPICUOUS DISCLOSURE.—A health insurance issuer shall provide the following notice, in 12-point bold type, in any insurance coverage offered in a secondary State under this part by such a health insurance issuer and at renewal of the policy, with the 5 blank spaces therein being appropriately filled with the name of the health insurance issuer, the name of primary State, the name of the secondary State, the name of the secondary State, and the name of the secondary State, respectively, for the coverage concerned:

'This policy is issued by _____ and is governed by the laws and regulations of the State of _____, and it has met all the

laws of that State as determined by that State's Department of Insurance. This policy may be less expensive than others because it is not subject to all of the insurance laws and regulations of the State of _____, including coverage of some services or benefits mandated by the law of the State of _____. Additionally, this policy is not subject to all of the consumer protection laws or restrictions on rate changes of the State of _____. As with all insurance products, before purchasing this policy, you should carefully review the policy and determine what health care services the policy covers and what benefits it provides, including any exclusions, limitations, or conditions for such services or benefits.'.

''(d) PROHIBITION ON CERTAIN RECLASSIFICATIONS AND PREMIUM INCREASES.—

''(1) IN GENERAL.—For purposes of this section, a health insurance issuer that provides individual health insurance coverage to an individual under this part in a primary or secondary State may not upon renewal—

''(A) move or reclassify the individual insured under the health insurance coverage from the class such individual is in at the time of issue of the contract based on the health-status related factors of the individual; or

''(B) increase the premiums assessed the individual for such coverage based on a health status-related factor or change of a health status-related factor or the past or prospective claim experience of the insured individual.

''(2) CONSTRUCTION.—Nothing in paragraph (1) shall be construed to prohibit a health insurance issuer—

''(A) from terminating or discontinuing coverage or a class of coverage in accordance with subsections (b) and (c) of section 2742;

''(B) from raising premium rates for all policy holders within a class based on claims experience;

''(C) from changing premiums or offering discounted premiums to individuals who engage in wellness activities at intervals prescribed by the issuer, if such premium changes or incentives—

''(i) are disclosed to the consumer in the insurance contract;

''(ii) are based on specific wellness activities that are not applicable to all individuals; and

''(iii) are not obtainable by all individuals to whom coverage is offered;

''(D) from reinstating lapsed coverage; or

''(E) from retroactively adjusting the rates charged an individual insured individual if the initial rates were set based on material misrepresentation by the individual at the time of issue.

''(e) PRIOR OFFERING OF POLICY IN PRIMARY STATE.—A health insurance issuer may not offer for sale individual health insurance coverage in a secondary State unless that coverage is currently offered for sale in the primary State.

''(f) LICENSING OF AGENTS OR BROKERS FOR HEALTH INSURANCE ISSUERS.—Any State may require that a person acting, or offering to act, as an agent or broker for a health insurance issuer with respect to the offering of individual health insurance coverage obtain a license from that State, except that a State many not impose any qualification or requirement which discriminates against a nonresident agent or broker.

''(g) DOCUMENTS FOR SUBMISSION TO STATE INSURANCE COMMISSIONER.—Each health insurance issuer issuing individual health insurance coverage in both primary and secondary States shall submit—

''(1) to the insurance commissioner of each State in which it intends to offer such coverage, before it may offer individual health insurance coverage in such State—

''(A) a copy of the plan of operation or feasibility study or any similar statement of the policy being offered and its coverage (which shall include the name of its primary State and its principal place of business);

''(B) written notice of any change in its designation of its primary State; and

''(C) written notice from the issuer of the issuer's compliance with all the laws of the primary State; and

''(2) to the insurance commissioner of each secondary State in which it offers individual health insurance coverage, a copy of the issuer's quarterly financial statement submitted to the primary State, which statement shall be certified by an independent public accountant and contain a statement of opinion on loss and loss adjustment expense reserves made by—

''(A) a member of the American Academy of Actuaries; or

''(B) a qualified loss reserve specialist.

''(h) POWER OF COURTS TO ENJOIN CONDUCT.—Nothing in this section shall be construed to affect the authority of any Federal or State court to enjoin—

''(1) the solicitation or sale of individual health insurance coverage by a health insurance issuer to any person or group who is not eligible for such insurance; or

''(2) the solicitation or sale of individual health insurance coverage by, or operation of, a health insurance issuer that is in hazardous financial condition.

''(i) STATE POWERS TO ENFORCE STATE LAWS.—

''(1) IN GENERAL.—Subject to the provisions of subsection (b)(1)(G) (relating to injunctions) and paragraph (2), nothing in this section shall be construed to affect the authority of any State to make use of any of its powers to enforce the laws of such State with respect to which a health insurance issuer is not exempt under subsection (b).

''(2) COURTS OF COMPETENT JURISDICTION.—If a State seeks an injunction regarding the conduct described in paragraphs (1) and (2) of subsection (h), such injunction must be obtained from a Federal or State court of competent jurisdiction.

''(j) STATES' AUTHORITY TO SUE.—Nothing in this section shall affect the authority of any State to bring action in any Federal or State court.

''(k) GENERALLY APPLICABLE LAWS.—Nothing in this section shall be construed to affect the applicability of State laws generally applicable to persons or corporations.

''SEC. 2797. PRIMARY STATE MUST MEET FEDERAL FLOOR BEFORE ISSUER MAY SELL INTO SECONDARY STATES.

''A health insurance issuer may not offer, sell, or issue individual health insurance coverage in a secondary State if the primary State does not meet the following requirements:

''(1) The State insurance commissioner must use a risk-based capital formula for the determination of capital and surplus requirements for all health insurance issuers.

''(2) The State must have legislation or regulations in place establishing an independent review process for individuals who are covered by individual health insurance coverage unless the issuer provides an independent review mechanism functionally equivalent (as determined by the primary State insurance commissioner or official) to that prescribed in the 'Health Carrier External Review Model Act' of the National Association of Insurance Commissioners for all individuals who purchase insurance coverage under the terms of this part.

''SEC. 2798. ENFORCEMENT.

''(a) IN GENERAL.—Subject to subsection (b), with respect to specific individual health insurance coverage the primary State for such coverage has sole jurisdiction to enforce the primary State's covered laws in the primary State and any secondary State.

''(b) SECONDARY STATE'S AUTHORITY.—Nothing in subsection (a) shall be construed to affect the authority of a secondary State to enforce its laws as set forth in the exception specified in section 2796(b)(1).

''(c) COURT INTERPRETATION.—In reviewing action initiated by the applicable secondary State authority, the court of competent jurisdiction shall apply the covered laws of the primary State.

''(d) NOTICE OF COMPLIANCE FAILURE.—In the case of individual health insurance coverage offered in a secondary State that fails to comply with the covered laws of the primary State, the applicable State authority of the secondary State may notify the applicable State authority of the primary State.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to individual health insurance coverage offered, issued, or sold after the date of the enactment of this Act.

SEC. _05. SEVERABILITY.

If any provision of the title or the application of such provision to any person or circumstance is held to be unconstitutional, the remainder of this title and the application of the provisions of such to any other person or circumstance shall not be affected.

SA 3492. Mr. DEMINT submitted an amendment intended to be proposed by him to the bill H.R. 3963, to amend title XXI of the Social Security Act to extend and improve the Children's Health Insurance Program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle C of title VI, add the following:

SEC. _____. ABOVE-THE-LINE DEDUCTION FOR HEALTH INSURANCE PREMIUMS AND OUT-OF-POCKET EXPENSES.

(a) IN GENERAL.—Section 62(a) of the Internal Revenue Code of 1986 (defining adjusted gross income) is amended by inserting after paragraph (21) the following new paragraph:

''(22) HEALTH INSURANCE PAYMENTS.—

''(A) IN GENERAL.—Any amount allowable as a deduction under section 213 (determined without regard to any income limitation under subsection (a) thereof) by reason of subsection (d)(1)(D) thereof for qualified health insurance and for any deductible and other out-of-pocket expenses required to be paid under such insurance.

''(B) QUALIFIED HEALTH INSURANCE.—For purposes of this paragraph—

''(i) IN GENERAL.—The term 'qualified health insurance' means insurance which constitutes medical care as defined in section 213(d) without regard to—

''(I) paragraph (1)(C) thereof, and

''(II) so much of paragraph (1)(D) thereof as relates to qualified long-term care insurance contracts.

''(ii) EXCLUSION OF CERTAIN OTHER CONTRACTS.—Such term shall not include insurance if a substantial portion of its benefits are excepted benefits (as defined in section 9832(c)).''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2007.

SEC. _____. USE OF HEALTH SAVINGS ACCOUNTS FOR NON-GROUP HIGH DEDUCTIBLE HEALTH PLAN PREMIUMS.

(a) IN GENERAL.—Section 223(d)(2)(C) of the Internal Revenue Code of 1986 (relating to exceptions) is amended by striking ''or'' at the end of clause (iii), by striking the period at the end of clause (iv) and inserting '', or'',

and by adding at the end the following new clause:

''(v) a high deductible health plan, other than a group health plan (as defined in section 5000(b)(1)).''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2007.

SEC. _____. CLARIFICATION OF DEFINITION OF GROUP HEALTH PLAN UNDER HIPAA.

(a) ERISA.—Section 733(a)(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191b(a)(1)) is amended by adding at the end the following: ''Such term does not include an arrangement maintained by an employer the sole effect of which is to provide reimbursement to employees for the purchase by such employees of health insurance coverage offered in the individual market (as defined in section 2791(e)(1)) of the Public Health Service Act), notwithstanding that the employer or an employee organization negotiates the cost or benefits of the arrangement.''.

(b) PHSA.—Section 2791(a)(1) of the Public Health Service Act (42 U.S.C. 300gg–91(a)(1)) is amended by adding at the end the following: ''Such term does not include an arrangement maintained by an employer the sole effect of which is to provide reimbursement to employees for the purchase by such employees of health insurance coverage offered in the individual market, notwithstanding that the employer or an employee organization negotiates the cost or benefits of the arrangement.''.

(c) IRC.—Section 9832(a) of the Internal Revenue Code of 1986 (relating to definitions) is amended by inserting before the period the following: '', except that such term does not include an arrangement maintained by an employer the sole effect of which is to provide reimbursement to employees for the purchase by such employees of health insurance coverage offered in the individual market (as defined in section 2791(e)(1)) of the Public Health Service Act), notwithstanding that the employer or an employee organization negotiates the cost or benefits of the arrangement.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to plan years beginning after December 31, 2007.

SA 3493. Mr. DEMINT submitted an amendment intended to be proposed by him to the bill H.R. 3963, to amend title XXI of the Social Security Act to extend and improve the Children's Health Insurance Program, and for other purposes; which was ordered to lie on the table; as follows:

Strike section 114 and insert the following:

SEC. 114. DENIAL OF PAYMENTS FOR EXPENDITURES FOR CHILD HEALTH ASSISTANCE FOR CHILDREN WHOSE FAMILY INCOME EXCEEDS 300 PERCENT OF THE POVERTY LINE.

(a) IN GENERAL.—Section 2105(c) (42 U.S.C. 1397ee(c)) is amended by adding at the end the following new paragraph:

''(8) DENIAL OF PAYMENTS FOR EXPENDITURES FOR CHILD HEALTH ASSISTANCE FOR CHILDREN WHOSE FAMILY INCOME EXCEEDS 300 PERCENT OF THE POVERTY LINE.—

''(A) IN GENERAL.—For child health assistance furnished after the date of the enactment of this paragraph, no payment shall be made under this section for any expenditures for providing child health assistance or health benefits coverage for a targeted low-income child whose family income exceeds 300 percent of the poverty line.

''(B) DETERMINATION OF FAMILY INCOME.—In determining family income under this title (including in the case of a State child health plan that provides health benefits coverage in the manner described in section 2101(a)(2)), a State shall base such determination on gross income (including amounts that would be included in gross income if they were not exempt from income taxation).''.

(b) PROHIBITION ON WAIVER OF REQUIREMENTS.—Section 2107(f) (42 U.S.C. 1397gg(f)), as amended by section 112(a)(2)(A), is amended by adding at the end the following new paragraph:

''(3) The Secretary may not approve a waiver, experimental, pilot, or demonstration project with respect to a State after the date of enactment of the Children's Health Insurance Program Reauthorization Act of 2007 that would waive or modify the requirements of section 2105(c)(8) (relating to denial of payments for expenditures for child health assistance for children whose family income exceeds 300 percent of the poverty line).''.

SA 3494. Mr. DEMINT submitted an amendment intended to be proposed by him to the bill H.R. 3963, to amend title XXI of the Social Security Act to extend and improve the Children's Health Insurance Program, and for other purposes; which was ordered to lie on the table; as follows:

On page 281, between lines 16 and 17, insert the following:

SEC. ___. POINT OF ORDER AGAINST LEGISLATION THAT RESULTS IN A TAKEOVER OF HEALTH CARE COVERAGE BY THE FEDERAL GOVERNMENT.

Title III of the Congressional Budget Act of 1974 is amended by adding at the end the following new section:

''POINT OF ORDER AGAINST LEGISLATION THAT RESULTS IN A TAKEOVER OF HEALTH CARE COVERAGE BY THE FEDERAL GOVERNMENT

''SEC. 316. (a)(1) IN GENERAL.—It shall not be in order in the Senate to consider any bill, resolution, amendment, amendment between Houses, motion, or conference report that—

''(A) imposes Federal Government mandates that reduce the number of Americans covered by private health insurance;

''(B) mandates through Federal law that any employer contributions or private wages that currently fund private health care coverage go to a Federally-run program for health care coverage; or

''(C) displaces the number of individuals in private health care coverage through an expansion or creation of a health care system run by the Federal Government by more than 5 percent of the total number of individuals affected by the expansion or creation of any such system.

''(2) DETERMINATIONS.—All determinations required by this subsection shall be made by the Congressional Budget Office.

''(b) SUPERMAJORITY WAIVER AND APPEAL.—

''(1) WAIVER.—This section may be waived or suspended in the Senate only by an affirmative vote of three-fifths of the Members, duly chosen and sworn.

''(2) APPEAL.—An affirmative vote of three-fifths of the Members of the Senate, duly chosen and sworn, shall be required in the Senate to sustain an appeal of the ruling of the Chair on a point of order raised under this section.''.

SA 3495. Mr. DEMINT submitted an amendment intended to be proposed by him to the bill H.R. 3963, to amend title XXI of the Social Security Act to extend and improve the Children's Health Insurance Program, and for other purposes; which was ordered to lie on the table; as follows:

Strike section 613.

SA 3496. Mr. COBURN submitted an amendment intended to be proposed by him to the bill H.R. 3963, to amend title XXI of the Social Security Act to extend and improve the Children's Health Insurance Program, and for other purposes; which was ordered to lie on the table; as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Children's Health Care First Act''.

SEC. 2. PROHIBITION ON FUNDING CONGRESSIONAL EARMARKS UNTIL ALL UNITED STATES CHILDREN HAVE OPTIMAL HEALTH INSURANCE.

Notwithstanding any other provision of law, the Secretary of Health and Human Services shall not allocate or make payments from any funds appropriated for congressionally directed spending items (as such term is defined for purposes of paragraph 5(d) of rule XLIV of the Standing Rules of the Senate) for fiscal year 2008 or any succeeding fiscal year until on or after the date on which the Secretary of Health and Human Services certifies to Congress that all children in the United States have optimal health insurance.

SEC. 3. TRANSFER OF EARMARK FUNDS TO SCHIP.

Notwithstanding any other provision of law, any funds appropriated to the Secretary of Health and Human Services or the Department of Health and Human Services for congressionally directed spending items (as such term is defined for purposes of paragraph 5(d) of rule XLIV of the Standing Rules of the Senate) for fiscal year 2008 or any succeeding fiscal year are hereby transferred and made available for providing allotments to States under section 2104 of the Social Security Act (42 U.S.C. 1397dd) until on or after the date described in section 2.

SEC. 4. ANNUAL REPORT ON NUMBER OF CHILDREN PROVIDED HEALTH INSURANCE THROUGH TRANSFERRED EARMARK FUNDS.

Beginning January 1, 2008, and annually thereafter until on or after the date described in section 2, the Secretary of Health and Human Services shall submit a report to Congress on the number of children who are provided child health assistance under a State child health plan under title XXI of the Social Security Act through funds transferred and made available under section 3 for providing allotments to States under section 2104 of such Act.

AUTHORITY FOR COMMITTEES TO MEET

AD HOC SUBCOMMITTEE ON DISASTER RECOVERY

Mr. DORGAN. Mr. President, I ask unanimous consent that the Ad Hoc Subcommittee on Disaster Recovery of the Committee on Homeland Security and Governmental Affairs be authorized to meet during the session of the Senate on Wednesday, October 31, 2007, at 2:30 p.m. in order to conduct a hearing entitled, ''Post-Catastrophe Crisis: Addressing the Dramatic Need and Scant Availability of Mental Health Care in the Gulf Coast.''

The PRESIDING OFFICER. Without objection, it is so ordered.